TESTIMONY BEFORE THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

of the

HOUSE COMMERCE COMMITTEE,

U.S. HOUSE OF REPRESENTATIVES

on the

"Assisted Suicide Funding Restriction Act of 1997"

by

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The Oregon Catholic Conference (Conference) represents the Catholic bishops of Oregon in the Archdiocese of Portland and the Diocese of Baker in service to Oregon's Catholic population of approximately 300,000 people.

In one of the last public acts before his death, the late Joseph Cardinal Bernardin wrote a moving letter to the U.S. Supreme Court Justices urging the court not to create any right to assisted suicide.

Cardinal Bernardin wrote:

> "Physician-assisted suicide is decidedly a public matter. It is not simply a decision made between patient and physician. Because life affects every person, it is of primary public concern. . . .
>
> Our legal and ethical tradition has held consistently that suicide, assisted-suicide, and euthanasia are wrong because they involve a direct attack on innocent human life. And it is a matter of public policy because it involves a violation of a fundamental human good."

Because life is a "primary public concern," and because physician-assisted suicide is "a matter of public policy," the Conference requests that the U.S. Congress address the issue of physician-assisted suicide and pass the "Assisted Suicide Funding Restriction Act of 1997."

The Conference makes this request because of its solemn obligation to advocate on behalf of life, particularly on behalf of

and in solidarity with the weakest and most vulnerable persons in society. The Conference's request is made with the highest regard and concern for the people of Oregon and the United States and is not intended as any sign of disrespect for Oregon's voters.

The Conference has particular interest in the issue of physician-assisted suicide. Catholic Church teaching is well articulated on this issue: the Church supports the dignity of the individual throughout life's journey from conception until natural death. Accordingly, the Conference opposes physician-assisted suicide and has been engaged significantly in the public debate in Oregon on this issue.

Brief History of Physician-Assisted Suicide on the West Coast

Ballot Measure 16 is the first legislation to be adopted anywhere in the world decriminalizing physician-assisted suicide. On election day, November 8, 1994, Ballot Measure 16 was approved narrowly by Oregon's voters 51%-49%. The Ballot Measure 16 official vote as published by Oregon's Secretary of State in the **1995-96 Oregon Blue Book,** was 627,980 "Yes" votes and 596,018 "No" votes, a difference of 31,962 votes. In Multnomah County, the state's most populous county, the margin in favor of Measure 16 was 33,413 votes. Outside Multnomah County, the opposition prevailed by a margin of 1,451 votes. The opponents prevailed in 21 of Oregon's 36 counties. A change of 16,000 votes from "Yes" to "No"

would have changed the outcome of the election. If information forthcoming subsequent to the November 8, 1994 election date would have been known by the electorate before they voted, the opponents believe the outcome of the election would have been changed.

Since 1988 the issues of physician-assisted suicide and euthanasia have been prominent in Oregon.

Having failed to qualify a proposition for California's statewide ballot in 1988, the Hemlock Society moved its national headquarters to Eugene, Oregon in August 1988. In June 1989, while the Oregon Legislative Assembly was considering the adoption of power-of-attorney for health care legislation, the proponents of assisted-suicide and euthanasia filed an initiative petition with the Oregon Secretary of State. The operative term "aid-in-dying" would have permitted the administration of a lethal injection by a physician.

In the face of a ballot-title challenge before the Oregon Supreme Court, as provided under Oregon's initiative election law, the petitioners withdrew their initiative. They announced they had secured the commitment of a state legislator who promised to introduce similar legislation in 1991 during the next regularly scheduled session of the Oregon Legislative Assembly.

In 1990 the proponents moved their efforts north to Washington State and filed an initiative to the Washington Legislature again permitting "aid-in-dying" and the administration of the lethal injection by a physician. The 1991 Washington State Legislature

did not adopt the measure. Instead, Initiative 119 was placed on the November 1991 statewide ballot where it was defeated 54%-46%.

In Oregon in 1991, S.B. 1141 was introduced by four state legislators. The bill received one hearing and died in committee. Once again, "aid-in-dying" was the cornerstone euphemism permitting a physician to administer a lethal injection.

In 1992, the proponents' focus shifted once again to California in the form of Proposition 161. "Aid in dying" would have allowed the administration of the lethal injection by a physician. Proposition 161 was defeated by the same margin as the vote in Washington State, 54%-46%. The opponents seized the imagery of a physician preparing a lethal injection for an elderly woman. That image would change the debate, the terms of the measure and lead to an entirely new and different campaign in Oregon in 1994.

Having learned from their defeats in Washington State (1991) and California (1992), the proponents of physician-assisted suicide and euthanasia dropped the lethal injection in their return to Oregon in 1994. In its pertinent section, Ballot Measure 16 states:

> "Nothing in this Act shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with this Act shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law." (Section 3.14)

Ballot Measure 16 was the sanitized version of the euthanasia

movement's public policy efforts. The doctors would not be directly involved in killing the patient. Instead, under the measure's terms, an adult ". . . may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with this Act." (Section 2.01)

Additionally, Ballot Measure 16's express language plays havoc with commonly understood words and definitions, e.g. suicide, assisted suicide, mercy killing and homicide. (See indented quote of Section 3.14 above)

Despite the express language of the initiative itself, the Oregon Supreme Court in its opinion issued on April 14, 1994 declared: ". . . we think it equally clear that the chief purpose of the measure is to affirmatively authorize and to create standards for physician-assisted suicide." Kane v. Kulongoski, 318 Or. 593,601, 871 P.2d 993 (1994).

New Information Subsequent to Election

(1.) Federal and State Funding of Physician-Assisted Suicide

Within days of the election, new information emerged which the opponents believe would have changed the outcome of the election. The Associated Press ran a wire story dated November 11, 1994 which included the following statement:

> "Another ambiguity about the new law is whether state taxpayers will be paying for doctors to prescribe lethal drugs. Dr. Paul Kirk, chairman of the Oregon Health Services Commission, said he believes the

> practice is covered under the state health care plan's provision for `comfort care' for the terminally ill."

On December 6, 1994, **The Statesman-Journal** ran a story under the headline "State could cover assisted suicide." The article included the following statement: "Jean Thorne, the state's Medicaid director, said physician-assisted suicide, if done according to the law, would be covered under a part of the Oregon Health Plan called comfort care."

The opponents of physician-assisted suicide believe that at least 16,000 votes would have switched sides had public financing of physician-assisted suicide become an issue in the campaign. As one who was deeply involved in the campaign across the state and to the best of my recollection, I do not recall hearing one word nor seeing one document indicating that physician-assisted suicide would be paid for using state and federal tax dollars.

On Sunday, February 16, 1997 **The New York Times** ran a front page story under the headline "Expense Means Many Can't Get Drugs for AIDS." The story stated: "The AIDS drug assistance programs in Arkansas, Nevada, South Dakota and Oregon do not cover any of the protease inhibitors, which block reproduction of the AIDS virus. Covering such drugs `would blow our budget out of the water,' said Lisa McAuliffe, coordinator of the Oregon program."

Oregon stands at the threshold of an unwise and dangerous public policy which will pay for a lethal overdose of drugs for terminally ill persons, but not provide benefits for drugs which

block reproduction of the AIDS virus to keep people alive. Public policy which pays for death and refuses to pay for life is morally bankrupt.

(2.) Lethal Overdose of Drugs Will Not Immediately Kill Patient in 25 Percent of Cases.

On December 4, 1994, less than one month after the election, investigative reporting by **The Oregonian** revealed startling information. In an article entitled "Dutch Researcher Warns of Lingering Deaths," **The Oregonian** reported on the study by a euthanasia doctor from the Netherlands, Dr. Pieter Admiraal:

> "Admiraal has overseen more than 100 euthanasia deaths. The study that he helped to coordinate will appear in the Journal of the Royal Dutch Society for the Advancement of Pharmacy.
>
> He said it chronicled more than 200 patients over a four-year period and quantified what Dutch physicians have known for years: Drugs work slowly for some people.
>
> The study showed that while 75 percent of the patients die within three hours, the remainder can last two days or longer. There is no way to predict who will die quickly and who will linger, Admiraal said.
>
> In the Netherlands, if a patient lingers, the physician often hastens death with a lethal injection. Here, doctors will not have that option."

The terms of Ballot Measure 16 reveal the startling nature of this information for Oregon. The measure expressly prohibits the use of the lethal injection. Section 3.14 provides in part: "Nothing in this Act shall be construed to authorize a physician or any other person to end a patient's life by **lethal injection**, mercy killing or active euthanasia. . . ." (emphasis added)

The Oregonian reporting continued:

> "The impetus for Measure 16 did not come from the medical community, but from right-to-die advocates, many of whom have experienced the anguish of watching loved ones endure degrading terminal diseases.
>
> The final wording in their initiative omitted references to lethal injections, unlike failed initiatives in Washington and California. This served to distance physicians from the assisted suicide process.
>
> The strategy worked. The Oregon Medical Association took a neutral stand, a factor cited by some as the turning point in the campaign."

The strategy to sanitize physician-assisted suicide by prohibiting the lethal injection and by distancing doctors from the act of suicide may have worked in the campaign; but it produced a fundamentally and fatally flawed piece of legislation which, according to Admiraal's research, will not work immediately in 25 percent of the cases. Commenting for the Oregon Medical Association, its president was quoted in **The Oregonian** article: " `That's going to terrify doctors,' Dr. Leigh Dolin, president of the Oregon Medical Association, said of Admiraal's research. . . . `I don't think 75 percent is good enough,' Dolin said."

Federal Patient Self-Determination Act

Ballot Measure 16 presents significant legal issues under the federal Patient Self-Determination Act (PSDA).

The Catholic Health Association (CHA), a national Catholic association consisting of U.S. Catholic hospitals and long-term

care facilities, their sponsoring organizations and systems, and other health and related agencies and services operated as Catholic facilities, filed an amicus brief with the U.S. Court of Appeals for the Ninth Circuit in Lee v. Oregon, 891 F.Supp.1429 (D. Or. 1995).

The CHA brief makes specific and significant reference to the federal PSDA and the requirements imposed on Catholic health care facilities in Oregon as a result of the passage of Ballot Measure 16.

In their amicus brief, CHA asserts:

> ". . . (PSDA) requires health care facilities to provide written information to each patient concerning `an individual's rights under state law . . . to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.' 42 U.S.C. 1395cc(f)(1)(A). Thus, if Measure 16 is upheld and assisted suicide is interpreted to be one of an individual's rights under state law, Catholic facilities may be forced to provide written information to their patients concerning an option inimical to their faith and, in their view, dangerous to their salvation. The government simply cannot compel such involuntary proselytizing ." (citation omitted).

Why A Federal Legislative Remedy Is Needed

(1.) Federal Financing

Ballot Measure 16, as indicated above, raises significant legal issues involving the people of Oregon and the United States through state and federal taxpayer support and financing of a most

controversial and objectionable activity, namely, physician-assisted suicide. Federal funding introduces the specter of the people of Oregon obligating the people of the United States to be involved in and to pay for an activity which is prohibited by the criminal laws of a majority of the states.

Federal law prohibiting ". . . with respect to Medicaid financing any amount expended for any item, or service, furnished for the purpose of causing, or the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing," (Section 6, "Assisted Suicide Funding Restriction Act of 1997) is required to assure the American people that their federal tax dollars will not be involved in any way in activity which is in violation of the criminal laws of the majority of states.

(2.) Clarification of Federal Patient Self-Determination Act

The federal Patient Self-Determination Act (PSDA) requires hospitals to provide written information to each patient concerning an individual's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. The hospital also is required to provide written policies respecting the implementation of such rights.

The federal penalty for not complying with the federal PSDA is

the loss of federal funding. The "Assisted Suicide Funding Restriction Act of 1997" would clarify the intent of the PSDA. This bill removes any clouds on federal Medicaid and Medicare funds from flowing to health care facilities which find physician-assisted suicide objectionable and which, therefore, refuse to provide information to patients regarding this objectionable activity.

Several Apparent Conflicts with Federal Law

(1.) Federal Drug Laws

Implementation of Ballot Measure 16 decriminalizing physician-assisted suicide may require the prescribing of barbiturates and other drugs for the intentional taking of human life - a purpose never approved by the Federal Food, Drug, and Cosmetic Act or the Controlled Substances Act.

In a **New England Journal of Medicine** November 3, 1994 article entitled "Death by Prescription: The Oregon Initiative," George J. Annas indicated that Ballot Measure 16 may violate federal drug laws:

> "To be lawful, a prescription for a controlled substance `must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice.' (Citation omitted) The question remains whether, under federal law, prescribing drugs for a patient to use to commit suicide would constitute a legitimate medical purpose. It is unclear whether, if a state authorizes a physician to engage in certain practices, they are considered `legitimate' under federal law, since the drafters of the federal statute certainly

> did not have this purpose in mind. What case law exists indicates that the physician must have some therapeutic purpose to prescribe lawfully."

(2.) Religious Freedom Restoration Act (RFRA).

Under RFRA a state may not substantially burden the exercise of religious freedom unless this is the most narrowly drawn means of serving a compelling state interest.

The CHA brief mentioned above says that even though Oregon's law "allows Catholic providers to transfer a patient rather than actually perform an assisted suicide, before the transfer the facility must enable the suicide by creating the documentary record required by law to permit the last act in the sequence, the prescription of the fatal medication."

> "Measure 16 forces Catholic health care providers to choose between their sincerely held religious beliefs and the requirements of the law by requiring them to:
> - Allow physicians on staff who assist in suicides.
> - Prepare documents enabling assisted suicides.
> - Inform patients of the option of committing suicide; and
> - As to the CHA, by prohibiting the expulsion of members who feel compelled by law to tolerate assisted suicides in their facilities."

(3.) Civil Rights

In a preliminary injunction against Oregon's Ballot Measure 16, U.S. District Court Judge Michael Hogan said questions have been raised as to whether a law selectively allowing assisted

suicide for people with AIDS and other disabilities violates the federal Americans with Disabilities Act.

Potential for Abuse

Finally, the Conference wishes to urge the U.S. Congress to examine very carefully the potential for abuse contained in a public policy of physician-assisted suicide. Certainly the Dutch experience with physician-assisted suicide and euthanasia should sound a clarion call to stop physician-assisted suicide before it begins. In September 1996, "Physician-Assisted Suicide and Euthanasia in the Netherlands" was issued as a report of Chairman Charles T. Candy to the U.S. House of Representatives' Subcommittee on the Constitution of the Committee on the Judiciary. This report clearly documents the Dutch movement from assisted-suicide to active euthanasia from the terminally ill to the chronically ill, from voluntary to non-voluntary euthanasia and from physical illness to mental suffering. The Dutch experience, the attempt to tolerate and regulate without decriminalizing physician-assisted suicide, has resulted in one year in more than 1,000 cases of involuntary euthanasia and the euthanizing of the mentally ill and severely handicapped newborns.

One of the tests of any piece of legislation on any issue should be the potential for abuse. The Dutch experience tells us that the potential for abuse in physician-assisted suicide is real,

serious and significant. Life itself is at risk in Oregon and in the United States with Measure 16, and all our lives are put in jeopardy in a society which rejects the fundamental ethic of respecting the dignity of the human person and not engaging in the killing of one person by another.

The British Parliament in a report on medical ethics wrote: "That prohibition (of intentional killing) is the cornerstone of law and of social relationships." Ballot Measure 16 strikes a fundamental blow at the cornerstone of life in Oregon and the United States.

An additional word of caution is necessary because of the high percentage of Oregon's population enrolled in managed care health plans. There is now starting to emerge in the secular press and in professional journals concern about the dangerous convergence of issues of managed care and physician-assisted suicide. Managed care has the potential for creating conflicts of interest for the doctor between obligations of advocacy for the patient and financial management of health care expenditures. When one adds physician-assisted suicide to the list of concerns, this mix of issues and policies adds to the reasons for physician-assisted suicide being unwise and dangerous public policy.

Conclusion

In conclusion, the Conference requests the U.S. Congress to adopt the "Assisted Suicide Funding Restriction Act of 1997." The Conference makes this request because of the serious and significant moral and public policy issues raised as a result of the passage of the first legislation anywhere in the world to decriminalize physician-assisted suicide, Ballot Measure 16.

Physician-assisted suicide crosses the boundary lines of morality, medical ethics and law. Passage of federal legislation will ensure that those of us in this nation who are opposed to physician-assisted suicide will not be forced either to contribute through our taxes to an activity which we find morally objectionable or to act in ways which compromise values central to our deeply held religious convictions.

Thank you for the opportunity to present this testimony on behalf of the Oregon Catholic Conference.